U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 25 July 2007

IN THE MATTER OF:

B.M.,
Claimant,

v. Case No.: 2002-BLA-5212

GLAMORGAN COAL CORPORATION,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Joseph E. Wolfe, Esquire
Andrew Delph, Esquire
For the Claimant

Timothy W. Gresham, Esquire
For the Respondent

DECISION AND ORDER AWARDING BENEFITS ON REMAND

Statement of the Case

This case involves a subsequent claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. § 901, et. seq. (Act), and the regulations promulgated thereunder.[1] A hearing thereon was conducted on May 14, 2003, in Abingdon, Virginia. A Decision and Order – Awarding Benefits was issued January 6, 2004, which was appealed. By *Decision and Order* dated March 23, 2005, the Benefits Review Board (Board) affirmed in part and vacated in part

[1] References to regulatory provisions are made to the 2006 version of Title 20 of the Code of Federal Regulations unless otherwise noted. Exhibits are referenced as follows: (1) Director's Exhibit is "DX"; (2) Claimant's Exhibit is "CX", and (3) Employer's Exhibit is "EX." References to the May 14, 2003 hearing transcript are designated as "TR."

and remanded this case with instructions for further consideration under the regulations, particularly the provisions at §§ 725.414, 725.309, and 718.304. Because Claimant was last employed as a coal miner for more than one year in West Virginia, the law of the United States Court of Appeals for the Fourth Circuit is controlling. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(*en banc*).

While the Board upheld this tribunal's finding of 23 years of coal mine employment, it vacated findings that the miner demonstrated a change in an applicable condition of entitlement under § 725.309 and that the miner presented evidence sufficient to establish invocation of the irrebuttable presumption at § 718.304 of the regulations. Moreover, the Board instructed this tribunal to determine the admissibility of certain medical evidence consistent with the limitations at § 725.414 and, in assessing whether the miner has demonstrated a change in an applicable condition of entitlement under § 725.309, the Board directed that only medical evidence developed subsequent to Administrative Law Judge Richard Morgan's August 18, 1998 denial of the miner's previous claim be considered. DX. 3.[2] Pursuant to this tribunal's Procedural Order Setting Briefing Schedule issued July 8, 2005, as extended, Respondent submitted a Brief on Remand. Claimant did not file a brief.

Summary of chest x-ray evidence under § 718.304(a)

The following new chest roentgenogram evidence is in the record:[3]

Exhibit #	Date of Study / Date of Reading	Physician	Qualifications B-Reader (B) / Board Cert. (BCR)	Film Quality	Reading
DX 16	11-27-00 12-01-00	DePonte (claimant's first	B, BCR[4]	1	1/1, p/p; B Comments: (1) status

[2] On February 25, 2000, the Board affirmed Judge Morgan's 1998 decision denying benefits. DX. 3. In his decision, Judge Morgan concluded that the miner suffered from simple coal workers' pneumoconiosis based on the biopsy evidence of record, but that the miner did not suffer from complicated coal workers' pneumoconiosis and had not demonstrated that he suffered from a totally disabling respiratory or pulmonary impairment. In concluding that the miner did not establish complicated coal workers' pneumoconiosis, Judge Morgan found that the readings of Drs. Wheeler and Fishman that the disease was not present outweighed the contrary interpretation of Dr. Robinette based on the superior radiological qualifications of Drs. Wheeler and Fishman. Moreover, the Board affirmed Judge Morgan's finding that the biopsy evidence, while establishing the presence of simple coal workers' pneumoconiosis, did not demonstrate the presence of complicated pneumoconiosis because there was no "equivalency determination" that the tissue analyzed on biopsy would "correspond in size to opacities viewed on (the) x-ray film."

[3] A "--" under the *Reading* column of the chart indicates that the physician did not provide a specific category reading under the ILO-U/C classification system. 20 C.F.R. §§ 718.102 and 718.202(a)(1).

[4] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completes an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

		affirmative interpretation)			post coronary artery by-pass; (2) right lung large opacity may be from pleural thickening rather than conglomerate mass. Recommend confirmation by computerized tomography.[5]
DX 16	11-27-00 12-18-01	Barrett (employer's rebuttal to claimant's first affirmative interpretation)	B, BCR	1	No parenchymal or pleural abnormalities consistent with pneumoconiosis. In the comments, Dr. Barrett notes "(o)? RUL (illegible) – Follow-up."
DX 14	04-10-01 04-10-01	Forehand (part of § 725.406 examination)	B	1	1/1, q/p; A (mass measured as 3 cm x 3 cm in the right upper lung zone)
DX 15	04-10-01 04-21-01	Barrett (part of § 725.406 examination)	B, BCR	1	Quality reading only.
DX 31	04-10-01 06-29-01	Wiot (employer's rebuttal to § 725.406 x-ray interpretation)	B, BCR	1	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Comments: Mass in right upper lung; rule out malignancy
DX 31	09-17-01 09-17-01	Hippensteel (employer's first affirmative	B	2	1/2, q/p; B?; parenchymal abnormalities

[5] In a separate statement dated December 1, 2000, Dr. DePonte states, in relevant part, the following:

> All rounded opacities type p/p are present in all lung zones with profusion 1/1. A large opacity Category B is present at the right lung apex. There is overlying pleural thickening in this region as well as mild pleural thickening in the left apex though this is not the usual presentation and location for pneumoconiosis, and this is likely from another etiology. It is possible that this large opacity located more centrally, however, in the right apex on this frontal projection represents focal pleural thickening rather than a conglomerate mass. Computerized tomography is recommended for further evaluation of this lesion.

DX. 16.

		interpretation			consistent with pneumoconiosis but no pleural abnormalities consistent with the disease
EX 15	10-30-02 11-07-02	Wheeler (employer's second affirmative interpretation)	B, BCR	3	No pleural or parenchymal abnormalities consistent with pneumoconiosis. Comments: "Oval 6 x 3 cm mass subapical RUL compatible with conglomerate TB more likely than tumor."
CX 2	01-02-03 01-02-03	Robinette (claimant's second affirmative interpretation)	B	1	2/3, q/r; B

Summary of other evidence under § 718.304(c)

Pursuant to § 718.304(c), Claimant also may present evidence that he suffers from complicated pneumoconiosis by "means other than those specified in paragraphs (a) and (b) of this section." This category of evidence includes reasoned, documented medical reports as well as CT-scan reports.

Medical reports

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be considered adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc). Statutory pneumoconiosis is established by reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). The following medical reports were admitted as evidence in the record:

A. THE DOL-SPONSORED PULMONARY EXAMINATION—DR. RANDOLPH FOREHAND

Dr. Forehand conducted the Department-sponsored examination of the miner and issued a report on April 10, 2001. DX. 14. He noted 24.5 years of underground coal mine employment ending in 1986. Dr. Forehand also reported a 34 year history of smoking one pack of cigarettes per day. The miner complained of daily productive cough, dyspnea of seven years' duration, angina, and orthopnea. His medicines included Coumedin, Pepcid, Avapro, and Baycol.

Examination of the lungs yielded findings of "breath sounds of normal quality and distribution" on auscultation. Cardiac examination revealed no thrills, gallop, or murmurs. A chest x-ray was interpreted as positive for the presence of simple and complicated pneumoconiosis. An EKG provided no evidence of acute changes. Ventilatory and blood gas testing produced non-qualifying values. The miner denied a history of tuberculosis, but acknowledged a history of heart disease and high blood pressure.

Dr. Forehand diagnosed the presence of complicated coal workers' pneumoconiosis based on his chest x-ray interpretation and "history." With regard to the etiology of the x-ray abnormalities, Dr. Forehand stated:

Coal dust exposure
R/O tuberculosis
R/O malignancy

Dr. Forehand concluded that the miner suffered from "significant lung injury" and was totally and permanently disabled from returning to his last coal mining job. He noted that complicated coal workers' pneumoconiosis was "the sole factor contributing to the respiratory impairment/disability." He recommended referral to another physician for a follow-up chest x-ray.

B. CLAIMANT'S MEDICAL REPORTS

Dr. Emory Robinette

Dr. Robinette issued a supplemental report on January 2, 2003. CX.2. He reiterated that he initially examined the miner in 1987 and did not see him again until 1997:

> In 1997 (the miner) subsequently returned to the office. At that time he provided records from Dr. Larry J. Foster, Pulmonary Associates of Kingsport, who recorded the patient had an abnormal chest x-ray. There was a large opacity in the upper lung zone consistent with coal workers' pneumoconiosis.

Dr. Robinette further reported that a CT-scan was performed at Johnson Memorial Hospital on June 5, 1998, which produced "evidence of nodular interstitial disease consistent with silicosis

and a 6 cm. mass in the apical region of the right upper lobe with multiple foci calcification consistent with a conglomerate pneumoconiosis." Dr. Robinette observed:

> These findings were felt to be consistent with marked progression of his radiographic abnormalities consistent with worsening interstitial disease and the evolution of conglomerate pneumoconiosis with a large opacity measuring 6 cm. in size. This was consistent with his occupational exposure and coal dust reticulation.

CX. 2.

On examination, he noted that the miner complained of being "short of breath on exertional activity" and he "difficulty walking more than a few feet without having to stop and rest." Dr. Robinette also noted complaints of orthopnea.

Examination of the lungs revealed diminished breath sounds without adenopathy of auscultation as well as prolongation of the expiratory phase. An EKG revealed normal sinus rhythm with nonspecific ST-T wave changes. Cardiac examination yielded findings of no murmur, rub, or gallop. The miner's diffusing capacity was mildly impaired at 70 percent of predicted, but his blood gas testing at rest produced non-qualifying values. Moreover, pulmonary function testing yielded non-qualifying values. A chest x-ray was interpreted as Category 2/3, q/r simple pneumoconiosis with a size B opacity of complicated pneumoconiosis in the right upper lung. Dr. Robinette commented that the x-ray revealed "diffuse interstitial fibrosis with a 4 to 5 cm. mass with pleural thickening in the right upper lobe." He concluded:

> There has been evidence of progression of his radiographic abnormalities with initial x-ray showing a general profusion abnormality of 1/0, but subsequent x-rays demonstrating marked progression of the profusion abnormalities with a 1997 x-ray documenting a Category A mass and a general profusion of 2/2. As part of his follow-up evaluation, sputum was checked for acid fast bacilli and there has been marked interval enlargement of the pulmonary mass with associated fibrotic reaction.

Based on his physical examinations of the miner as well as certain medical data of record, Dr. Robinette diagnosed the presence of complicated coal workers' pneumoconiosis:

> There has been progressive scarring and distortion of his pulmonary parenchyma and the interval development of complicated pneumoconiosis over the past 10 years. This condition is obviously exacerbating his complaints of dyspnea. Obviously, (the miner) is totally disabled from working in and around the coal mining area because of his radiographic abnormalities and this condition is chronic and progressive in nature and will most likely reduce his longevity significantly. There is no evidence of any atypical infection which would explain his clinical presentation.

CX. 2.

Dr. Robinette testified at the May 14, 2003 hearing that he first examined the miner in 1987 at the request of Claimant's counsel for an assessment of whether the miner suffered from occupational pneumoconiosis. TR. at 23. Dr. Robinette did not examine the miner again until 1998:

> The subsequent treatment was in 1998 through 2003, and that was requested by (the miner's) private physician, Dr. Topaddi (sic)[6] in Wise, to evaluate the evolution of X-ray changes which were concerning to the private physician . . ..

TR. 23. From 1998 to 2003, Dr. Robinette treated the miner and examined him every three or four months "and then a little less frequently recently because of the documentation of the stability of (the) lesions." TR. at 24. He stated that the x-rays from 1998 "were markedly abnormal, with general dust participation with a profusion of 2 over 2 and large rounded opacities present" and he was "certainly concerned that this represented other (etiologies), such as cancers or infectious agents." TR. at 24. However, Dr. Robinette noted that the lesions had "not been growing at a rate that one would anticipate" if the miner suffered from "a malignancy." TR. at 24-25. He stated:

> Malignant tumors typically double in the chest every thirty to sixty to ninety to 120 days. And if you had a four centimeter mass in your chest five years ago, obviously, you would have expired as a consequence of a primary malignancy . . .. The x-rays were basically reviewed with the suspicion that this all represented dust particulation and scarring, and the development of Progressive Massive Fibrosis.

TR. at 24-25. In this vein, Dr. Robinette testified that he sees four to five new cancer patients each month who live, on average, six months after such an initial visit. TR. at 33.

Dr. Robinette tested the miner for infections and granulomatous diseases. TR. at 25. He testified:

> The thing that was sort of challenging to us was to try to exclude any atypical infection. There was one culture reported from one sputum that showed that mycobacterium species, called Mycobacterium Pergenium, which is not typically associated with infection or invasion of the lung parenchyma. Sometimes we see a typical mycobacterium species which can cause infections but they tend to cause something called cavitation of the lungs. In other words you get holes in the lungs and people get sick. People lose weight, they cough up blood, they cough up copious quantities of sputum, and look very, very chronically ill from this particular process.

TR. at 25. He noted that he has collected Claimant's sputum "over the past years" for analysis and stated that he has:

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[6] The correct spelling is Dr. Tholpady.

> . . . never grown anything like mycobacterium and tuberculosis out of (the miner's) lungs, but have grown Perinem on one occasion and Avian on another occasion. The . . . accounts were very low and would not suggest that he would have an active invasion infection with that disorder.

TR. at 31. As a result, Dr. Robinette stated that he would "rule out" mycobacterium tuberculosis as the cause of the large opacity on the miner's x-ray. TR. at 31. On cross-examination, Dr. Robinette explained the microbacterium abiem complex:

> It's a non-contagious form of (myco)bacterium species that . . . they get from breathing dirt and soil. And it's very commonly found in my practice. There's individuals that would worry about it or those individuals who have gone repeatedly on different cultures or show evidence of actual infection.

TR. at 43. Here, he found that the large mass in the miner's lung was not due to this condition:

> One early culture out of three showed one or two columns, which would not (qualify) as infection. It states it's there and that's the reason we've repeated these cultures and we've never grown that organism out repeatedly and never grown out any particular pathogen.

TR. at 44. On cross-examination, Dr. Robinette was asked whether the miner's body could heal itself of a lung infection:

> [Y]ou can't clear that kind of organism if you've actually got an infection in it. In other words, it requires five antibiotics for twenty-four months before you can suppress that bacteria, if it's actually growing.

TR. at 44. Further, Dr. Robinette stated:

> Treatment is worse with M-Abiem than it is in TB, because the organism is much more difficult to kill, and it's more fastidious. In other words, it grows in areas where it's very difficult for the antibiotics to treat. You've got to use like five drugs, which are relatively toxic, to get rid of it. And I don't think anybody can spontaneously clear it, who has significant x-ray abnormalities. None of my patients ever spontaneously cleared it, but they stay sick from it.

TR. at 45.

Dr. Robinette emphasized that he considered both infectious and non-infectious granulomatous diseases:

> [W]e've considered all of those fugal infections. That's one reason the sputum specimens have been sent to the state laboratory, their culture for both acid-fast and fungi. And we've never grown any pathogen-fungi from his sputum at any time in the past.

TR. at 35. Dr. Robinette considered whether the large opacity in the miner's lung was due to some form of histoplasmosis or sarcoidosis. TR. at 31. He testified:

> We considered all those differential diagnoses of chest disease. Sarcoidosis is associated with typical mediastin or huge lymph nodes, some constitutional symptoms which are specific. You have some very significant function abnormalities with Sarcoidosis, which we did not see in (the miner). Histoplasmosis causes a somewhat different radiographic presentation. You certainly get changes but you get . . . calcifications throughout the lungs. I see several cases of histoplasmosis, both acute and chronic each year and we have to treat those corresponding ones.

TR. at 31-32. Dr. Robinette concluded that he found no evidence of sarcoidosis or histoplasmosis on the miner's chest x-rays. TR. at 32. On cross-examination, Dr. Robinette confirmed that the miner did not suffer from Sarcoidosis because "[f]unctionally, if you'll look at patients with Sarcoid, they have a severe reduction in their DLCO, severe restrictive lung disorder occurring." TR. at 40. He stated that he treats 200 to 300 patients with typical or atypical Sarcoid and atypical Sarcoid patients will "have skin lesions, kidney lesions, eye lesions, . . . a variety of organs can be attacked from Sarcoid." TR. at 41.

Dr. Robinette testified that he has examined and treated more than 150 to 200 patients with progressive massive fibrosis. TR. at 34. Based on the January 1, 2003 chest x-ray, when compared with a prior CT-scan of the miner, Dr. Robinette opined:

> I can state that I feel that (the miner) does have complicated pneumoconiosis based on the fact that if you'll look at the x-rays very carefully, you clearly document that there has been the evolution of a large rounded spot, or opacity in his lungs, superimposed from a background of pneumoconiosis and this has been proven both on a routine chest x-ray and CT scans. I would need to go from 1997 through 2003 to come up with that conclusion. This is consistent with the fibrogenic reaction that we see in certain individuals. We recognize that some miners are more predisposed to developing abnormal x-rays than others.
>
> I've had miners that worked forty years in the mines who had very little dust particulation, and I've had individuals who have worked ten years in an environment which was very dusty, coal dust, rock dust, rock drillers, whatever their vocation was, who had horrible x-ray abnormalities (consistent) with Progressive Massive Fibrosis.

TR. at 26-27. Dr. Robinette explained that, "[a]s a treating physician, I certainly feel more comfortable about making specific conclusions and diagnoses, based on serial follow-up and serial evaluations in terms of making sure that people do not have another diagnosis." TR. at 38.

When questioned about latency of the disease, Dr. Robinette stated that complicated pneumoconiosis may develop even after exposure to coal dust ends:

> I think there's a scientific base for the evolution of radiographic changes after the coal miner ceases employment in the mines and ceases dust exposure. If you recognize that there's a fibrogenic or fibrotic process that occurs as a consequence of lung inflammation in these individuals, it's very similar to the process that patients with rheumatoid arthritis develop. In other words, they start off with sore joints and stiffness, but they progress to joint destruction and crooked hands and crooked knees and crooked ankles. Literature often tells us and often states, much to my chagrin, that once coal dust ceases, exposure ceases that x-rays do not change, and as a practicing pulmonologist for the past twenty years, I see a fair number of individuals who develop significant radiographic changes, despite the fact that they've ceased all dust exposure. And it's consistent with a fibrogenic reaction.

TR. at 28-29.

In addition, on cross-examination, Employer's counsel noted that, in 1998, Dr. Robinette described a six centimeter mass in the miner's lung whereas, in 2003, the mass was described as a four or five centimeter mass. TR. at 47. Counsel then asked Dr. Robinette whether this represented a regression:

> No, it's not a regression, sir. The difference is that you're looking at both CAT scans versus . . . regular chest x-rays and there's a difference in your ability to measure from side to side in one versus the other. It's a Category B mass. The chest x-ray dated 1/2/03 was reported as four centimeters, but the CAT scan is about six centimeters in 1998. But I did have the opportunity to review the record from Dr. Foster and I think he said it was about four centimeters at that time. And then – I think they tried to do a needle biopsy on that area before they had him on anticoagulation therapy and did not think that there was any malignancy.

TR. at 47. In sum, Dr. Robinette testified that the large mass in the miner's lung "has grown slightly" since 1998, even though it has "not doubled in size" as one would expect if the mass was malignant. TR. at 46-47.

Although the miner's pulmonary function and blood gas testing yielded non-qualifying values, Dr. Robinette continued to diagnose the presence of complicated coal workers' pneumoconiosis:

> I have had a few patients in the past who have maintained their lung function. They tend to live a little longer in terms of life span. They certainly don't seem to die of severe heart failure and severe (dyspnea) . . ..

TR. at 35.

At the hearing, Dr. Robinette testified that he received a master's degree in Microbiology from the Medical College of Virginia. TR. at 21. He then received a medical degree from the

East Virginia Medical School in Norfolk, Virginia. TR. at 21-22. Dr. Robinette is board-certified in internal medicine with a subspecialty in pulmonary diseases. TR. at 22. He is also a NIOSH certified B-reader. TR. at 22.

Dr. Robinette stated the following regarding the composition of his medical practice in Virginia:

> My practice is limited to pulmonary disease, both referral and my private patients I provide care to. We see approximately 25 patients per day when I'm in the office. We're typically in the office four days per week. Of that group, about 20% of my patient population at this time are either former coalminers or coalminers who are preparing to be former coalminers, sort of, the end-stage of their occupation. They come in with a variety of suggestive complaints.

TR. at 22-23.

Dr. Robinette served as Regional Director for Tuberculosis Control in Virginia for ten years, ending in 1995. TR. at 22 and 29. His work as Regional Director entailed the following:

> [B]asically the diagnosis in TB for the Health Department was a direct extension of my training in pulmonary disease. TB's a highly contagious public health threat. And as such, the State of Virginia mandates that people who are at high risk for TB infections or who have x-ray abnormalities undergo a very rigorous screening, and this includes both x-rays and sputum analysis for acid-fast percelli, to make sure that they're not a public health threat. We monitored and treated individuals and had supervised therapy, to individuals who actually had tuberculosis. Typically, I only saw maybe two to three new cases of TB within five counties per year. It was not a great number.
>
> We monitored all of the old cases of tuberculosis that (were) healed and we monitored persons who had positive skin tests who moved into the region and one of the largest populations of folks that I had an opportunity to provide care to were at the Montessori School in Grundy. There were a large number of African immigrants who came in to the school there and had positive skin tests and so they all had to be treated and screened properly.

TR. at 29-30. Dr. Robinette is also the co-author of some publications, particularly in the area of lung carcinoma. DX. 16.

Dr. Donald Rasmussen

Dr. Rasmussen examined and tested the miner and issued a report on February 12, 2001. DX. 16. He noted complaints of shortness of breath for 15 years and that the miner "now becomes dyspneic after climbing a flight of stairs." He further reported complaints of a chronic

productive cough, orthopnea, and "occasional paroxysmal nocturnal dyspnea." Claimant noted that he had a "recent negative tuberculin skin test."

Dr. Rasmussen reported a 36 pack year history of smoking cigarettes, which the miner quit in 1996. He also noted 24.5 years of underground coal mine employment ending in 1986, where the miner worked mostly as a roof bolter and continuous miner. Examination of the lungs yielded findings of normal breath sounds with no rales, rhonchi, or wheezes. The EKG produced results within normal limits. Ventilatory testing was non-qualifying, but revealed a "slight irreversible obstructive insufficiency." Blood gas testing was also non-qualifying. Dr. Rasmussen reported that the miner's maximum breathing capacity was normal, but his single breath carbon monoxide diffusing capacity was moderately reduced.

Based on Dr. Patel's x-ray interpretation, Dr. Rasmussen stated that, while the miner retained the pulmonary capacity to perform his last regular coal mining job, it was "medically reasonable to conclude the patient does have complicated coal workers' pneumoconiosis which arose as a consequence of his coal mine employment."[7]

Dr. Rasmussen received his medical degree from the University of Utah College of Medicine. DX. 16. He is board-certified in internal medicine and forensic medicine. He is also a NIOSH-certified B-reader. Dr. Rasmussen has served in the Division of Pulmonary Medicine, Southern West Virginia Clinic in Beckley, West Virginia since March of 1995. He has also served as Adjunct Clinical Instructor for Respiratory Therapy at the College of West Virginia since 1987. Dr. Rasmussen has been appointed to NIOSH committees related to occupational pneumoconiosis and has testified before the West Virginia legislature as well as both houses of the United States Congress on matters related to coal workers' pneumoconiosis. He was the recipient of the American Public Health Association Presidential Award in 1969 for "exceptional service in the fight against black lung." Dr. Rasmussen is the author or co-author of numerous publications related to coal workers' pneumoconiosis.

C. EMPLOYER'S MEDICAL REPORTS

Dr. A. Dahhan

Dr. Dahhan examined and tested the miner, reviewed certain medical records, and issued a report on October 20, 2002. EX. 15. He reported 24.5 years of underground coal mine employment, which ended in 1986. Dr. Dahhan further noted that the miner smoked one pack of cigarettes from the ages of 16 to 52, for a total of 36 pack years.

[7] Dr. Patel's February 15, 2001 interpretation of a study dated February 12, 2001 provided that the miner suffered from Category 2 pneumoconiosis in all lung zones with a Category B large opacity. DX. 16. However, Claimant has designated and submitted the December 1, 2000 interpretation of Dr. DePonte as well as the January 2, 2003 interpretation of Dr. Robinette as his affirmative evidence under § 725.414(a)(2)(i) (2005). As a result, the interpretation of Dr. Patel must be excluded as it exceeds the evidentiary limitations and, accordingly, the portion of Dr. Rasmussen's report referencing the interpretation is excluded.

The miner complained of a daily productive cough and occasional wheezing, but Dr. Dahhan noted that the miner was not on bronchodilators. Examination of the lungs revealed "good air entry to both lungs" with "[n]o crepitation, rhonchi, or wheeze . . .." Cardiac examination demonstrated "artificial aortic valve sounds" with no gallop or murmur.[8]

Dr. Dahhan pointed to the miner's lack of respiratory impairment as support for a conclusion that he does not suffer from complicated pneumoconiosis:

> Patients with complicated coal workers' pneumoconiosis usually have a restrictive ventilatory impairment with the presence of crackles on clinical examination of the chest; clubbing and edema on inspection of the digits; restrictive pattern on pulmonary function studies with reductions in all components of lung volumes as well as a reduction in the diffusion capacity and an alteration in the blood gas exchange mechanisms at rest that worsens with exercise. None of these abnormalities are found in (Claimant's) case . . ..

EX. 15.

Dr. Kirk Hippensteel

Dr. Hippensteel examined and tested the miner September 17, 2001, reviewed certain medical data of record, and issued a report on October 5, 2001. DX. 31. He reported 24.5 years of underground coal mine employment ending in April 1986 when the miner was laid off "after he was having problems with chest pain at his job as a section foreman in the mines." Dr. Hippensteel also noted a history of smoking one pack of cigarettes per day for 34 years.

The miner reported that he had a negative tuberculosis skin test "a couple of years ago" and that "Dr. Robinette has investigated his sputum for TB organisms three times in the last two years with negative results." Examination of the lungs revealed "no wheezes or rales in any part of the lung, including right upper lobe." Moreover, Dr. Hippensteel reported "good air movement bilaterally." Cardiac examination produced findings of a regular heart rhythm with no gallop.

A chest x-ray demonstrated Category 1/2 simple coal workers' pneumoconiosis in all six lung zones. Dr. Hippensteel also noted a three centimeter by six centimeter variable density in the right upper lobe that raised a question regarding whether it was a large opacity from pneumoconiosis. To better delineate the chest x-ray findings, Dr. Hippensteel found that a high resolution CT-scan dated September 17, 2001 confirmed the presence of a three centimeter by six centimeter density in the right upper lung. He stated:

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[8] Dr. Dahhan reported that a chest x-ray revealed Category 1/1 simple coal workers' pneumoconiosis. Moreover, a "rounded opacity . . . seen in the right upper zone (was) highly suspicious for bronchogenic carcinoma or possible old tuberculosis infection." Dr. Dahhan further noted that he could not rule out the "possibility of a large opacity." Employer has designated and submitted the x-ray interpretations of Drs. Hippensteel and Wheeler in support of its affirmative case under § 725.414(a)(3)(i). Thus, Dr. Dahhan's x-ray interpretation must be excluded as it exceeds the evidentiary limitations, and, accordingly, the portion of Dr. Dahhan's report referencing the interpretation is excluded.

> This composite of radiographic findings favors granulomatous disease over coal workers' pneumoconiosis as a cause for these abnormalities since coal workers' pneumoconiosis is not associated with mediastinal lymphyadenopathy or pleural changes. Small rounded opacities and large opacities . . . can come from granulomatous disease as well as coal workers' pneumoconiosis.

DX. 31. However, Dr. Hippensteel considered other medical data, such as non-qualifying pulmonary function and blood gas testing, to militate against a finding of complicated pneumoconiosis:

> Since complicated pneumoconiosis regularly causes impairment in pulmonary function, the fact that this man does not have any pulmonary dysfunction is strongly against complicated coal workers' pneumoconiosis as a diagnosis. The finding of normal function does not rule out simple pneumoconiosis, which can frequently occur without associated pulmonary impairment. Nonetheless, the small rounded opacities seen on this man's chest x-ray and CT-scan could well be from granulomatous disease which has produced more localized intense inflammation and not created changes in pulmonary function referable to this process. Tuberculosis, histoplasmosis, and sarcoidosis are all types of granulomatous disease, but are not the only diseases of the general public that cause granulomatous inflammation in the lungs and the lack of findings on blood tests to support histoplasmosis or sarcoidosis do not rule these diseases out and a negative skin test for tuberculosis does not rule out tuberculosis completely. I would expect, however, that tuberculosis, if it were untreated, would cause progressive changes in function, which has not been the case in this man.

DX. 31. Dr. Hippensteel did conduct a "Treadmill Stress Test" of the miner and noted that the heart rate achieved was "65% of the maximal age-predicted heart rate" and the testing was stopped due to dyspnea. He noted that the miner did not complain of chest pain and there was no evidence of ischemia.

Dr. Hippensteel noted that he reviewed 76 x-ray interpretations since the September 5, 1973 study. He noted:

> Temporally, this man developed nodules in his lungs and rapidly progressive changes over the last decade. Even though coal workers' pneumoconiosis is considered a latent and progressive disease, the rapidity of development of changes when none were previously noted by most interpreters, speaks more to an acute inflammatory process unrelated to his prior coal dust exposure with this process self limited and now quiescent without having caused impairment in function.

Dr. Hippensteel also took note of the biopsy evidence of record and concluded that it did not support a finding of complicated coal workers' pneumoconiosis:

> The associated lack of any impairment in ventilatory or gas exchange function is strongly against complicated coal workers' pneumoconiosis as a diagnosis in this man. The normal pulmonary function studies and blood gases in this man show that the findings in his lungs are more localized and less inflammatory than could be expected if this actually represented complicated coal workers' pneumoconiosis. Even though a specific diagnosis has not been made in this man, the findings are much more compatible with some type of non-infectious or infectious granulomatous disease that has become quiescent by his own body defenses rather than complicated pneumoconiosis since such granulomatous disease can create significant lesions on chest x-ray without significant impairment in function, although it would be very unusual for complicated pneumoconiosis to do this.

DX. 31.

In a supplemental report dated January 15, 2002, Dr. Hippensteel reviewed CT-scans dated April 11, 2000, December 14, 2000, and May 9, 2001. DX. 31. He stated the following:

> I think the conclusions reached in my report dated 10/5/01 remain valid with a reasonable degree of medical certainty. The findings from these CT scans corroborate conclusions reached in this report when added to the other data obtained on examination and review of additional records in this case.

DX. 31.

Dr. Hippensteel was deposed on April 24, 2003. EX. 19. He noted that he has practiced in the field of pulmonary diseases since 1978. EX. 19 at 5. Dr. Hippensteel stated that the miner was not on any medications for breathing; rather, he was only on medications for blood pressure, stomach problems, and cholesterol. EX. 19 at 8. He noted that a chest x-ray underlying his examination revealed the presence of a three by six centimeter density in the right upper lobe:

> That raised a question about a large opacity from pneumoconiosis. I thought that there was evidence of prior cardiac surgery. I thought that he had bilateral apical pleural capping which I noted was a pleural disease, not compatible with coal workers' pneumoconiosis.

EX. 19 at 9-10. Dr. Hippensteel reported that the miner's CT-scan confirmed the presence of the large opacity in his right upper lobe with stranding to the pleural surface as well as to the hilar area of the right lung. EX. 19 at 10.

Dr. Hippensteel testified that the CT-scan is a better tool than the x-ray to determine the composition of the three by six centimeter lesion. EX. 19 at 12. Dr. Hippensteel then concluded that the miner suffered from simple coal workers' pneumoconiosis, but not complicated pneumoconiosis:

> I thought that the combinations of findings here favored that it was a granulomatous lesion in his right upper lobe and that it was not possible to separate out all of the other small lesions as being granulomatous or simple coal workers' pneumoconiosis because the pattern of those individual small lesions are similar, especially when they are not calcified.
>
> So I couldn't say there isn't a composite of both granulomatous inflammation and coal workers' pneumoconiosis versus excluding one versus the other in looking at the opacities in the rest of the lungs besides this large opacity in the right upper lobe.

EX. 19 at 14-15. With regard to the large opacity, Dr. Hippensteel stated that "its calcification and pattern in the midst of what else was there on the chest x-ray and CT-scan strongly favored granulomatous disease over coal workers' pneumoconiosis as a cause for that large opacity." EX. 19 at 15. He further noted that a large mass of coal workers' pneumoconiosis usually occurs on a background of a "high profusion of small opacities." EX. 19 at 16.

Dr. Hippensteel turned to Dr. Robinette's records of treating the miner and stated that he thought that Dr. Robinette found the presence of "mycobacterium avium," which "is a bacteria that is called an atypical mycobacteria which is a group of organisms that include tuberculosis." EX. 19 at 18. He stated that "[i]t is a noncontagious kind of tuberculosis that more often affects people that have immune compromise than it does affect people who are of normal immune status." EX. 19 at 18. Dr. Hippensteel states:

> I think that as I have found from the records of Dr. Robinette . . . that this man has actually had that organism isolated and I think that specifically is the culprit for this lesion in his right upper lobe.

EX. 19 at 18.

When asked about the miner's negative tuberculosis test results, Dr. Hippensteel stated that his diagnosis is unaffected as "this type of atypical bacterium does not create as positive of an antibody reaction that creates a positive skin test as regular tuberculosis." EX. 19 at 30. He further noted:

> Just having a negative TB skin test does not rule that out. And in fact the finding of that organism on cultures I think shows that it was the probable organism that made this lesion develop in (the miner's) right upper lobe.

EX. 19 at 30. In describing atypical tuberculosis, Dr. Hippensteel stated:

> [T]his isn't as aggressive as what regular TB is. It is usually better controlled by the body than regular TB, it doesn't create as much of a reaction to the tissues as what TB would create.

> So when the body does get control of it can stop and not progress any further. And I think that's what appears to have been the case dating back to '98, and has kept it under control since that time.

EX. 19 at 50-51.

Employer's counsel noted that the lesion first appeared as a six centimeter lesion in 1997 and is still a six centimeter lesion and asked Dr. Hippensteel the significance of this observation:

> I think it's some sort of acute process that came on acutely, more quickly than you would expect the development of a large opacity from coal workers' pneumoconiosis.
>
> And that this process developed, created a problem and then got controlled by this person's body. And that is much more in keeping with an infection with such an organism as this versus complicated coal workers' pneumoconiosis.

EX. 19 at 20.

On cross-examination, Dr. Hippensteel noted the presence of q and p opacities on x-ray, which are "rounded" opacities consistent with the presence of coal workers' pneumoconiosis. EX. 19 at 32. He also noted that rounded opacities are consistent with the presence of granulomatous diseases too. EX. 19 at 46. He further stated that the mycobacterium peregrinum "contaminant" normally does not "do anything" to the lungs, except "[i]t creates inflammation that creates a granulomatous mass." EX. 19 at 40-41. Dr. Hippensteel noted that the granulomatous mass would not transfer oxygen like regular lung tissue, but asserted that a mass of complicated pneumoconiosis is different:

> Complicated pneumoconiosis causes lung disease overall in areas around where the lesion is, not just what it does at the lesion. But if you do have a localized lesion that doesn't have all of this disturbance of function around it by the fibrosis that is leading to the lesion, then that can happen without a change in function.

EX. 19 at 42. Dr. Hippensteel acknowledged the presence of simple coal workers' pneumoconiosis in the background of the large lesion and, although he could not "separate out how much is from that versus how much is from granulomatous inflammation, . . . simple pneumoconiosis looks to be at least part of what shows up on the x-ray outside the area of this lesion." EX. 19 at 43. Further, Dr. Hippensteel agreed that pneumoconiosis was present inside the large opacity based on biopsy evidence of record. EX. 19 at 43.

Dr. Hippensteel stated that complicated pneumoconiosis is a conglomeration of nodules of simple pneumoconiosis. EX. 19 at 44. He doubted that the miner in this case suffered from complicated pneumoconiosis because testing over time did not reveal a respiratory impairment. EX. 19 at 45. However, when asked whether complicated pneumoconiosis may exist in the absence of a loss of lung function, Dr. Hippensteel stated:

> I'm saying it is not likely to. Again, when we put all the things together in this case, when you add that on to it it's another factor against this being complicated pneumoconiosis.
>
> It doesn't mean that there aren't cases where it doesn't occur, but it makes it less likely to be the problem when it doesn't occur.

EX. 19 at 45-46.

Dr. Hippensteel graduated with a medical degree from Indiana University. DX. 31. He is board-certified in internal medicine with a subspecialty in pulmonary diseases and critical care medicine. He is also a NIOSH-certified B-reader. Dr. Hippensteel has served as Assistant Clinical Professor of Medicine at the University of Virginia School of Medicine since April of 1980. He is the co-author of two publications and one abstract.

CT-scan evidence[9]

Exhibit #	Date of Scan/ Date of Reading	Physician	Qualifications B-Reader (B) / Board Cert. (BCR)	Proffering party	Reading
CX 1	12-14-00 12-15-00	DePonte	B, BCR	Claimant's affirmative CT-scan interpretation	"5 x 2 cm. right apical mass. The configuration and appearance of this is entirely consistent with a conglomerate mass from pneumoconiosis. A lung carcinoma cannot be entirely excluded. It is likely that this patient has had old films over the last several years. These should be obtained for comparison with the current study and would aid in excluding a

[9] Claimant also submitted a CT-scan interpretation dated April 11, 2000 from Dr. Coburn that was included among the several items in Director's Exhibit 16. It was referred to and included in a report of office visit by Dr. Robinette on September 26, 2000, which was a treatment record, but not in Dr. Robinette's medical report, CX 2, of January 2, 2003. DX. 16. Dr. Coburn, whose radiological qualifications are not of record, concluded that the scan revealed the following:

> CWP with progressive massive fibrosis in the right upper lobe. No change in the size of the lesion when compared to the previous exam. Because of the asymmetry, this continues to be an area of concern and I would recommend follow-up in the future . . ..

DX. 16. In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-__, BRB No. 04-0812 BLA (June 29, 2007) (en banc) (J. McGranery and J. Hall, concurring and dissenting), the Board clarified that each party is entitled to submit one CT-scan interpretation of each CT scan undergone by a claimant in support of its affirmative case. Claimant and Employer have each submitted a CT-scan interpretation, each of which is determined to be within the evidentiary limits clarified by the Board in *Harris*. Even if Dr. Coburn's interpretation should be excluded, there would be no prejudice, and the outcome of the case would not be affected. Dr. Coburn's interpretation, in any event, would be entitled to little weight because Dr. Coburn's radiological qualifications are unknown as compared to those of the dually-qualified Drs. DePonte and Wheeler as well as Dr. Hippensteel, a B-reader and board-certified pulmonary specialist.

					carcinoma." "Diffuse parenchymal interstitial abnormalities consistent with pneumoconiosis"
EX 18	12-14-00 12-10-01	Wheeler	B, BCR	Employer's rebuttal of claimant's CT-scan interpretation	No pneumoconiosis. "Oval well defined 6 cm wide and 3 cm thick mass in posterior subapical RUL contains tiny calcified granulomata in its medial portion and involves upper oblique fissure compatible with conglomerate TB more likely than histoplasmosis. Few linear scars extend from mass to adjacent pleura." "Few tiny linear scars and nodules in posterolateral subapical LUL compatible with TB unknown activity probably healed."

EX 19 at 10; DX 31	09-17-01 09-17-01	Hippensteel[10]	B	Employer's affirmative CT-scan interpretation	"3 x 6 cm density in right upper lobe with some stranding to pleural surface and left hilum. This is associated with scattered speckling of calcifications within this lesion. There is a mild increase in rounded interstitial opacities in mediastinal lymph nodes with the largest of these a 2 cm diameter subcarinal node. There is pleural thickening over both upper lobes."

Dr. DePonte reviewed the December 14, 2000 CT-scan and issued a report on that date. CX. 1. She noted that one centimeter thick contiguous axial slices were obtained through the thorax. Dr. DePonte found the following:

> In the right upper lobe posteriorly is a lobular, elongate approximately 5 x 2.5 mass. This contains some punctuate areas of calcification. The margins are mixed with some partially well-circumscribed areas but also with some speculation. No hilar or mediastinal adenopathy is seen.

[10] In footnote 8 of its March 23, 2005, *Decision*, the Board noted that Dr. Hippensteel referenced consideration of CT-scans dated April 11, 2000, December 4, 2000, and May 9, 2001 in his deposition assessment of Claimant's right, upper lung lesion. (Slip opinion at 8; EX 19 at 14) The April 11, 2000, CT-scan was the one interpreted by Dr. Coburn; the reference to December 4, 2000, appears to reflect a clerical error in the deposition transcript, since there is no such CT scan in the record, but there is a December 14, 2000, CT-scan interpreted by Dr. Wheeler and admitted in evidence. Dr. Hippensteel also referred to April 11, 2000, December 14, 2000, and May 9, 2001, CT-scans together in his supplemental report dated January 15, 2002. DX 31. There is no May 9, 2001, CT-scan interpretation admitted or referenced other than by Dr. Hippensteel in the evidentiary record. The reference to the May 9, 2001, CT scan, therefore, is not a reference to admissible evidence of record. Assuming that Dr. Hippensteel meant to reference the December 14, 2000, CT-scan, and that his reference to that CT-scan is an interpretation, it must be excluded pursuant to § 725.414(a)(3)(ii), because Employer has already submitted Dr. Wheeler's rebuttal interpretation of the December 14, 2000 CT-scan. Dr. Hippensteel's is the only interpretation by Employer of Dr. Coburn's April 11, 2000 CT-scan. *See Keener* and *Harris*, *supra*. However, the references are deemed not to taint Dr. Hippensteel's opinion to the extent that it need be excluded, because the references do not significantly affect the ultimate outcome or probative value of his opinion. Dr. Hippensteel relied on sufficient admissible medical data in rendering this opinion, specifically his interpretation of the September 17, 2001 CT-scan, to conclude with reasonable medical certainty, in his opinion, that the lesion did not constitute complicated pneumoconiosis, and to render his other references to CT-scans, in effect, cumulative.

> The lung parenchyma shows changes of pneumoconiosis with diffuse small rounded opacities particularly in the upper lung zones. Coalescence of the opacities is noted on the left in the same location as the large mass on the right. No pleural effusions.
>
> A small hiatal hernia is present.
>
> An aortic valvular prosthesis is present. Mild dilation of the ascending aorta is present which may be related to previous aortic stenosis.

CX. 1. Based on her observations, Dr. DePonte rendered the following conclusions:

> 1) 5 x 2 cm right apical mass. The configuration and appearance of this is entirely consistent with a conglomerate mass from pneumoconiosis. A lung carcinoma cannot be entirely excluded. It is likely that this patient has had old films over the last several years. These should be obtained for comparison with the current study and would aid in excluding a carcinoma.
>
> 2) Diffuse parenchymal interstitial abnormalities consistent with pneumoconiosis.
>
> 3) Status post aortic valve replacement.
>
> 4) Dilation of the ascending aorta which may represent post-stenotic dilation.
>
> 5) Hiatal hernia.

CX. 1.

Dr. DePonte was deposed on April 23, 2003. CX. 3. She stated that interpreting a CT-scan is different than interpreting a chest x-ray. CX. 3 at 10. Dr. DePonte explained:

> There is more information in here, plus there are so many more images to look at. You can see in some ways in some areas some better detail of certain parts of the lung because you don't have all of the overlying soft tissues that are superimposed on the standard radiograph.

CX. 3 at 10. Dr. DePonte noted that a CT-scan will corroborate ILO classifications on x-ray, but the ILO classification system does not apply to CT-scans because while both methods of testing "are looking at essentially the same anatomy and pathology," the reader is "looking at it at an expressly different perspective." CX. 3 at 12. She further stated that "[t]he determination of the size of structures on the CT-scan is somewhat more accurate than a normal chest x-ray." CX. 3 at 13.

Dr. DePonte concluded that, based on the miner's CT-scan and chest x-rays, he suffers from complicated pneumoconiosis. CX. 3 at 14. In particular, she noted:

> The type of large opacity is a Category B and the size for the classification purpose is 5.5 centimeters, which would make that Category B.

CX. 3 at 14. When asked whether pneumoconiosis could manifest after Claimant left the mines in April of 1986, Dr. DePonte responded affirmatively:

> Just because you have exposure, you know maybe for a couple of years, toward the end it may not manifest itself on a radiograph until years after the exposure ends.

CX. 3 at 17. Dr. DePonte stated that "[r]adiographic pneumoconiosis does not occur without some deposition of coal dust or silica within the lungs." CX. 3 at 19. Moreover, she clarified that a miner "can still get the larger opacities with the 1/1 profusion" and, "[i]n fact as the large opacities form, the large profusion will fall and come into the large opacities, (and) the background profusion may decline." CX. 3 at 22.

Dr. DePonte specifically concluded that the large opacity in the miner's lung was not tuberculosis:

> Tuberculosis usually does not present as a large mass. You will see more of an area of consolidation. It occurs in the lung apex. We have seen active cases of TB over the years, but nothing like this.

CX. 3 at 27. Dr. DePonte stated that there was a progression of the size B opacity from the time of a 1997 x-ray study[11]:

> If you look, it is very subtle, you have all the overlying rib shadows here. There is an opacity here that is about 3 centimeters . . .. Then there is another opacity with some smaller ones around that . . .. This measures just over 2. You sum that together and it gives you a B opacity of 5. It is two separate lesions. Two large ones and also smaller ones around that. If you look on the subsequent film, you will find one of these is more large or was an oval opacity here and all these lung markings that were present up here have increased, and this area, this conglomerate mass of the lung essentially pulls the smaller opacities together. Although you make the argument none of the other readers saw the opacities, you can see this can be very subtle.

CX. 3 at 27-28.

[11] In its brief, Employer argues that the 1997 x-ray study is irrelevant to determining whether the miner has met the threshold requirements of § 725.309. The Board agreed in its *Decision and Order*. While the 1997 study will not demonstrate a change in the miner's condition since the denial of his prior claim, Dr. DePonte's review of older studies is helpful in demonstrating changes occurring in the miner's lungs over time. Thus, as with Dr. Hippensteel, Dr. DePonte reviewed inadmissible x-ray studies in presenting her expert x-ray opinion. This does not, however, affect the probative value of her opinion as Dr. DePonte relied on sufficient admissible medical data to support her opinion, *i.e.* studies from the miner's first claim, which are admissible under. § 725.309(d)(1). TR. at 21-22.

Discussion and Conclusions of Law

A determination of whether the miner suffers from complicated pneumoconiosis in a claim filed under § 725.309 must be based on consideration of all admissible evidence generated after the denial of his prior claim which is in the record. Further, it must be determined whether the miner's complicated pneumoconiosis, if present, arose out of exposure to coal mine dust.

Notably, in *The Daniels Co. v. Mitchell*, 479 F.3d 321 (4th Cir. 2007), the court noted that the miner's x-rays and CT-scan "showed significant abnormalities in his lungs, including opacities greater than one centimeter in diameter, which could be consistent with pneumoconiosis and entitle him to the irrebuttable presumption of total disability." The court then determined that "[t]he miner must also independently establish" that his complicated pneumoconiosis arose out of coal mine employment under § 718.203.

The Board recently applied this holding in an unpublished decision, *W.L.C. v. Westmoreland Coal Co.*, BRB No. 06-0927 BLA (June 26, 2007) (unpub.). In that subsequent claim involving complicated pneumoconiosis, the Board held that:

> [S]hould the administrative law judge find the newly submitted evidence sufficient to establish the existence of complicated pneumoconiosis pursuant to 20 C.F.R. § 718.304, claimant will have established a change in an applicable condition of entitlement under 20 C.F.R. § 725.309.

Slip op. at 8. Moreover, because the claimant established more than ten years of coal mine employment, the Board held that:

> . . . claimant is entitled to a rebuttable presumption that his complicated pneumoconiosis arose out of coal mine employment. Employer would have the burden of producing sufficient evidence to rebut the presumption. 20 C.F.R. § 718.203(b).

Slip op. at 8-9. With this guidance in mind, this tribunal has examined the newly submitted evidence.

With respect to the chest x-ray evidence, the provisions at § 718.202(a)(1) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

The November 27, 2000 x-ray study was interpreted as positive for the presence of simple and complicated pneumoconiosis by Dr. DePonte although she noted that the "large opacity may be from pleural thickening rather than conglomerate mass." She recommended a CT-scan for further evaluation of the lesion. Dr. Barrett, on the other hand, concluded that the study revealed no parenchymal or pleural abnormalities consistent with pneumoconiosis.

Dr. DePonte graduated *Magna Cum Laude* from the University of Virginia with a *Bachelor of Arts* in Biology. She then received her medical degree from Hahnemann Medical College and Hospital in 1980, where she was awarded "Distinction" in medicine and where she belonged to the AOA Honor Medical Society. She is board-certified in diagnostic radiology. While she served her residency in Diagnostic Radiology at North Carolina Baptist Hospital, she also served an internship at the Hospital in the area of Internal Medicine. She has been the co-author of several publications. Dr. DePonte is also a NOISH-certified B-reader. DX. 16. During her April 23, 2003 deposition, Dr. DePonte testified that a significant percentage of her practice is related to black lung:

> I would look at several hundred films a year specifically for black lung. Many of my patients who are here for other problems manifest black lung, although they are not in the legal system yet or may never be.

CX. 3 at 14-15.

The record reveals that Dr. Barrett is a dually-qualified physician, but his *curriculum vitae* is not in the record. On balance, greater weight is accorded Dr. DePonte's interpretation of the study. Her *curriculum vitae* reports that she was awarded "Distinction" in medicine and she testified that a significant percentage of her practice involves patients with black lung disease. Indeed, she testified that she reviews "several hundred films a year specifically for black lung."

The April 10, 2001 x-ray study was interpreted by Dr. Forehand, a B-reader, as positive for the presence of simple and complicated pneumoconiosis. Dr. Wiot, on the other hand, noted the mass in the miner's right, upper lung, but concluded that there were no parenchymal or pleural abnormalities consistent with pneumoconiosis on the x-ray.

Dr. Wiot received his medical degree from the University of Cincinnati College of Medicine. DX. 31. He is board-certified in radiology and is a NIOSH-certified B-reader. Dr. Wiot has served as Professor Emeritus of Radiology at the University of Cincinnati since 1988. He has also served as a consulting radiologist at the Cincinnati Veterans' Administration Hospital since 1962. Dr. Wiot has served on the American College of Radiology Task Force on Pneumoconiosis since 1969. He is the co-author of numerous publications and textbook chapters in the field of radiology, including articles related to coal workers' pneumoconiosis. Dr. Wiot has served as a consultant for the Journal of Occupational Medicine since 1987. He is also a NIOSH consultant and served as Chair of the Workgroup for the ILO Classification system from 1987 to 1988.

Dr. Forehand's *curriculum vitae* is not in the record. Given the superior radiological qualifications of Dr. Wiot, it is determined that this x-ray study does not support a finding of simple or complicated pneumoconiosis.

Dr. Hippensteel interpreted the September 17, 2001 study as demonstrating Category 1 simple pneumoconiosis and, possibly, complicated pneumoconiosis with a size B opacity. Dr. Hippensteel questioned whether the size B opacity was the result of the miner's exposure to coal dust. Dr. Hippensteel is a NIOSH-certified B-reader. His interpretation supports a finding that the miner suffers from simple pneumoconiosis, and it is not inconsistent with a finding of complicated pneumoconiosis.

Dr. Wheeler concluded that the October 30, 2002 study did not yield findings of simple or complicated pneumoconiosis. Dr. Wheeler received his undergraduate degree from Harvard College and then obtained his medical degree from Harvard Medical School. DX. 3 at 4[12]. He is board-certified in radiology and serves as an Associate Professor of Radiology at Johns Hopkins University. DX. 3 at 7. Dr. Wheeler testified that he "developed computer systems for the department and for (his) section in pneumoconiosis for the last 20 years but (his) major interest is in clinical work and general patient care." DX. 3 at 9. He stated that, as part of his duties at Johns Hopkins Hospital, he "run(s) the Pneumoconiosis Section which deals with cases sent to us from various companies and law firms from around the country." DX. 3 at 10. The Pneumoconiosis Section of the radiology department "started as a referral from government agencies for problem cases." DX. 3 at 14-15. Dr. Wheeler testified that "[t]he bulk of the work is for ongoing industrial surveillance for several large firms, both for asbestos and silica exposures." DX. 3 at 16. Dr. Wheeler also interprets "all of the chest x-rays from the Baltimore City Tuberculosis Clinic." DX. 3 at 17. There are no contrary interpretations of the October 30, 2002 x-ray study, so that it does not support a finding of simple or complicated pneumoconiosis.

Finally, Dr. Robinette, a NIOSH-certified B-reader, interpreted the January 2, 2003 x-ray study as demonstrating the presence of Category 2/3 simple pneumoconiosis as well as complicated pneumoconiosis with a size B opacity. Dr. Robinette testified that he has treated 150 to 200 patients who suffered from progressive massive fibrosis. There are no other interpretations of this study. As a result, the study supports a finding of simple and complicated pneumoconiosis.

I. PRESENCE OF SIMPLE COAL WORKERS' PNEUMOCONIOSIS ESTABLISHED

In recent years, the x-ray studies demonstrate worsening of simple pneumoconiosis in the miner's lungs. Although Drs. Barrett, Wiot, and Wheeler found no parenchymal or pleural abnormalities consistent with pneumoconiosis on review of the studies before them, Drs. DePonte, Forehand, Hippensteel, and Robinette have concluded otherwise. Progression of the disease is documented from the Category 1/1 readings by Drs. DePonte and Forehand on the November 27, 2000 and April 10, 2001 films, respectively, to Dr. Hippensteel's finding of

[12] The district director has identified the miner's previous claim as *Director's Exhibit* 3, which consists of 1,100 pages. References to *Director's Exhibit* 3 in this paragraph are made to Dr. Wheeler's November 19, 1998 deposition transcript wherein he sets forth his credentials.

Category 1/2 pneumoconiosis on the September 17, 2001 film, and Dr. Robinette's observation of Category 2/3 pneumoconiosis more than one year later on the January 2, 2003 film. This progression is consistent with the presence of pneumoconiosis, which is a progressive and irreversible disease. *Lane Hollow Coal Co. v. Lockhart*, 137 F.3d 799, 803 (4th Cir. 1998) (pneumoconiosis is a progressive and irreversible disease). Moreover, under these circumstances, it is proper to accord greater weight to the most recent study of record (January 2, 2003), as it post-dates other newly submitted studies by one to three years. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984) (it is proper to accord greater weight to the most recent x-ray study of record). This study was interpreted by Dr. Robinette, a NIOSH-certified B-reader, as positive for the presence of Category 2/3 pneumoconiosis. There are no contrary interpretations of this study. Thus, a preponderance of the x-ray evidence demonstrates the presence of simple pneumoconiosis.

II. PRESENCE OF COMPLICATED PNEUMOCONIOSIS DUE TO COAL DUST EXPOSURE ESTABLISHED

With regard to whether the miner suffers from complicated coal workers' pneumoconiosis, Drs. Barrett, Wiot, Dahhan[13], and Wheeler noted the presence of a large mass in the miner's right upper lung, but they did not classify it as a size B opacity. On the other hand, Drs. DePonte, Forehand, Rasmussen[14], Hippensteel, and Robinette did identify a size B opacity on certain x-ray studies. Dr. Hippensteel questioned whether the opacity he marked as size "B" on the ILO classification form was pneumoconiosis. As explained below, upon consideration of the medical opinions and CT-scan evidence in conjunction with the chest x-ray evidence, this tribunal concludes that the miner has a size B opacity (complicated pneumoconiosis) in his right, upper lung, which is caused by his exposure to coal dust.

Drs. Wiot, Wheeler, Dahhan, and Hippensteel did not diagnose the presence of a size B opacity caused by coal dust exposure on the ILO classification form because they opined that the lesion was due to other causes.[15] Other suggested causes for development of the lesion included sarcoidosis, histoplasmosis, tuberculosis, and cancer. These physicians suggest that the lesion is not complicated coal workers' pneumoconiosis because: (1) the miner has exhibited no respiratory or pulmonary impairment on ventilatory and blood gas testing; (2) Dr. Robinette's clinical testing yielded evidence of mycobacterium avium, an atypical bacteria that produces certain forms of tuberculosis, which may lead to development of such a lesion; (3) the lesion has

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[13] Dr. Dahhan's opinion is accorded little probative value as he relies on his x-ray interpretation, which was not admitted into the record because it was in excess of the evidentiary limitations. § 725.414(a)(3)(i); *Keener v. Peerless Eagle Coal Co.*, 23 B.L.R. 1-__ (2007) (en banc).

[14] Dr. Rasmussen's opinion is accorded little probative value as he relies on the x-ray interpretation of Dr. Patel, which was not admitted into the record because it was in excess of the evidentiary limitations. § 725.414(a)(2)(i). *See also Keener, supra*.

[15] Dr. Barrett found no parenchymal or pleural abnormalities consistent with pneumoconiosis. He noted the presence of something in the miner's right, upper lung and recommended follow-up. He did not specify the size or possible etiology of what he observed in the right, upper lung. As a result, his opinion is accorded little weight on grounds that it is not well-reasoned.

remained unchanged since 1997; and (4) complicated pneumoconiosis usually occurs on the background of a high profusion of small opacities.

A. No respiratory or pulmonary impairment

One argument presented by Employer's experts in support of a finding of no complicated pneumoconiosis is that the miner's ventilatory and blood gas tests have produced non-qualifying values. Dr. Hippensteel explains:

> Complicated pneumoconiosis causes lung disease overall in areas around where the lesion is, not just what it does at the lesion. But if you do have a localized lesion that doesn't have all of this disturbance of function around it by the fibrosis that is leading to the lesion, then that can happen without a change in function.

EX. 19 at 42. Thus, Dr. Hippensteel testified that complicated pneumoconiosis may occur even in the absence of a loss of lung function, although "it is not likely to." EX. 19 at 42. On the other hand, he agreed that pneumoconiosis was present inside the large opacity based on biopsy evidence of record. EX. 19 at 43.

Here, the miner's pulmonary function and blood gas testing yielded non-qualifying values. Notably, however, in the most recent examination of record on January 2, 2003, Dr. Robinette noted complaints of shortness of breath on exertion and that the miner had "difficulty walking more than a few feet without having to stop and rest." During his September 2001 examination of the miner, Dr. Hippensteel noted that the miner's "Treadmill Stress Test" was stopped due to complaints of dyspnea and that the miner achieved "65% of the maximal age-predicted heart rate." Dr. Robinette agreed with Dr. Hippensteel that, although not typical, he has treated patients in the past who suffered from complicated pneumoconiosis and "maintained their lung function . . .." TR. at 35.

This tribunal is persuaded that, while complicated pneumoconiosis typically produces disabling lung function, the statute and regulations do not require demonstrating such disability prior to finding complicated pneumoconiosis established. Drs. Hippensteel and Robinette concede that a person may suffer from complicated pneumoconiosis and retain his or her lung function, even though it is not the norm. In this case, the miner's complaints of shortness of breath during Dr. Robinette's examination as well as the fact that Dr. Hippensteel stopped the "Treadmill Stress Test" due to complaints of dyspnea indicate that the miner is experiencing some respiratory problems despite the fact that his blood gas and ventilatory testing has yielded non-qualifying values thus far. A finding of complicated coal workers' pneumoconiosis is not precluded on this basis in this case.

B. Mycobacterium avium and other potential causes

Drs. Wheeler and Hippensteel attribute development of the lesion in the miner's right, upper lung to tuberculosis. Specifically, Dr. Hippensteel notes that Dr. Robinette found the presence of mycobacterium avium during his testing of the miner in 1997. Dr. Hippensteel explains that mycobacterium avium "is a bacteria that is called an atypical mycobacteria which is

a group of organisms that include tuberculosis." EX. 19 at 18. Dr. Hippensteel further noted that this bacteria "does not create as positive an antibody reaction" such that a negative TB skin test does not rule out its presence. Dr. Hippensteel states that mycobacterium avium is "some sort of acute process" that can develop more quickly than complicated pneumoconiosis and, when the body does get control of it can stop and not progress any further." EX. 19 at 20, 50-51.

On the other hand, Dr. Robinette persuasively concludes that he would "rule out" mycobacterium avium as the cause of the lesion. TR. at 31.[16] He notes that he has collected the miner's sputum "over the past years" and has:

> . . . never grown anything like mycobacterium and tuberculosis out of (the miner's) lungs, but have grown Perinem on one occasion and Avian on another occasion. The . . . accounts were very low and would not suggest that he would have an active invasion infection with that disorder.

TR. at 31. Notably, Dr. Robinette found that the miner did not exhibit evidence of an actual tuberculosis infection, nor did his sputum cultures repeatedly yield findings of avian:

> One early culture out of three showed one or two columns, which would not (qualify) as infection. It states it's there and that's the reason we've repeated these cultures and we've never grown that organism out repeatedly and never grown out any particular pathogen.

TR. at 44. Dr. Robinette also explained that the human body cannot "clear" a mycobacterium avium infection without the use of five antibiotics over a 24 month period of time. TR. at 44. He noted that this form of tuberculosis is "much more difficult to kill" than other types of TB because "it's more fastidious." TR. at 45.

There is inadequate evidence in the record to support Dr. Hippensteel's conclusion that the lesion "acutely" appeared in 1997 by x-ray study, where there were no lesions in the miner's lungs ten years earlier. The record is devoid of x-rays or CT-scans in this interim ten year period so that it cannot reasonably be determined when the lesion started to appear or how it may have progressed during this time period.

On balance, this tribunal finds that the lesion was not caused by mycobacterium avium. First, there is insufficient data in the record to support Dr. Hippensteel's conclusion that the lesion appeared "acutely" as opposed to over a period of time. Second, Dr. Robinette

[16] Dr. Robinette also persuasively explains that the lesion is not malignant as it has not been growing at the rate expected if it was cancerous. TR. at 24-25. Dr. DePonte agrees. Having treated numerous cancer patients, Dr. Robinette further stated that, if the miner had a malignant four centimeter mass in his lungs four years ago, then he "would have expired as a consequence of the primary malignancy . . .." A biopsy of the lesion produced findings of pneumoconiosis, but not cancer. Moreover, in his treatment of the miner, Dr. Robinette testified that he considered both infectious and non-infectious granulomatous diseases as the cause of the lesion. He excluded sarcoidosis because there are "some very significant function abnormalities with Sarcoidosis, which we did not see in (the miner)." TR. at 31-32. He also excluded histoplasmosis as the cause of the lesion because it "causes a somewhat different radiographic presentation" such as calcifications throughout the lungs, which were not present in this case. TR. at 31-32.

persuasively "rules out" mycobacterium avium as the cause of the lesion because he noted that he grew Avian from one early sputum culture, but did not grow it from any subsequent cultures and never grew mycobacterium. Third, the early culture produced only "one or two columns" of Avian, which Dr. Robinette testified would not be enough to qualify as an infection. Fourth, Dr. Robinette persuasively explains that a person cannot "self-cure" of the mycobacterium avium infection. Rather, a regime of five antibiotics over a 24 month period of time is required to treat the infection.

This tribunal accords Dr. Robinette's opinions greater weight than those of Drs. Hippensteel, Dahhan, Wheeler, and Wiot because he has superior medical credentials for purposes of this particular case. Although his radiological qualifications are not superior to those of Drs. Wheeler and Wiot, this case involves more than x-ray interpretations. Dr. Robinette's qualifications relating to testing, diagnosing, treating, and monitoring patients with various forms of tuberculosis and pneumoconiosis make him more credible than the other physicians of record. Medical testing, such as sputum cultures, TB skin testing, and physical examinations, provides more comprehensive data upon which Dr. Robinette is qualified to render an opinion. As a pulmonologist, Dr. Robinette testified that he has examined and treated more than 150 to 200 patients with progressive massive fibrosis. Twenty percent of his patient population is current or former coal miners. Of particular significance in this case, for ten years, Dr. Robinette served as the Regional Director for Tuberculosis Control in Virginia. Through this position, he monitored, treated, and screened persons with tuberculosis. Thus, Dr. Robinette was immersed in a much broader spectrum of useful testing to determine whether certain diseases are present in a patient's lungs.

Dr. Robinette brings a high level of expertise to this case. Indeed, the record reveals that, under Dr. Robinette's direction, the miner underwent x-rays, CT-scans, TB skin tests (which have yielded negative results), and sputum tests. Given Dr. Robinette's superior qualifications and experience in testing, diagnosing, and treating persons with a myriad of lung disorders (including progressive massive fibrosis and tuberculosis), this tribunal accords greatest weight to his well-reasoned, well-documented opinions.[17]

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[17] In accordance with the Board's directive that Dr. Robinette's status as a "treating physician" be assessed under 20 C.F.R. § 718.104, this tribunal will do so. However, as noted above, it is Dr. Robinette's considerable experience in treating patients with progressive massive fibrosis and/or tuberculosis, among other lung conditions, that lends greatest support to the credibility of his opinions.

Pursuant to 20 C.F.R. § 718.104(d), a fact-finder must consider the following factors in determining whether to accord a medical expert status as a "treating physician": (1) nature of the relationship; (2) duration of the relationship; (3) frequency of the treatment; and (4) extent of the treatment. Here the first two factors do not appear to be in dispute. Dr. Robinette testified that he served as the miner's pulmonologist and that he first examined the miner at the request of miner's counsel in 1987 to determine whether the miner suffered from coal workers' pneumoconiosis. He did not subsequently examine the miner until 1998, when the miner was referred to Dr. Robinette by Dr. Thopaldy, the miner's personal physician. At the time, Dr. Thopaldy was concerned with x-ray changes occurring in the miner's lungs. Starting in 1998 to 2003, Dr. Robinette examined and tested the miner every two to three months. After Dr. Robinette determined that the mass was not growing at a significant rate, he treated the miner with less frequency. In sum, it is proper to find that Dr. Robinette was the miner's treating pulmonologist. The extent of his treatment of the miner ranged from ordering x-rays and CT-scans, obtaining sputum for analysis on multiple occasions, and conducting physical examinations over time subsequent to denial of the miner's prior claim. As a result, his qualifications in this case include serving as the miner's treating physician.

C. Progression of the mass

Dr. Hippensteel was questioned about Dr. Robinette's finding of a four or five centimeter mass on x-ray in a January 2, 2003 report. EX. 19 at 22. Dr. Hippensteel noted that he measured the mass at three by six centimeters in an earlier report and that Dr. Robinette "just used one dimension" and the mass was measured as "smaller." EX. 19 at 22. Dr. Hippensteel testified:

> I guess it would make it more likely to be something that is healing to some degree rather than something that is getting worse over time as one would expect coal workers' pneumoconiosis to progress over time.

EX. 19 at 23. He reiterated that this is consistent with the presence of mycobacterium avium as opposed to complicated coal workers' pneumoconiosis. EX. 19 at 23.

Initially, it is noted that Dr. Robinette's observation of a "four or five centimeter" mass provides, as conceded by Dr. Hippensteel, only one of the two dimensions of the mass. It is unclear which dimension was noted by Dr. Robinette and it is deemed to be unreasonable, under such circumstances, to infer or declare that the mass was somehow "healing." Moreover, Dr. Robinette persuasively testified at the hearing that the mass was not improving; rather, differences in his measurements of the mass stemmed from the technologies used, in that he recorded a smaller measurement in relation to the 2003 x-ray than the larger measurement noted on the 1998 CT-scan. Dr. Robinette agreed with Drs. Hippensteel and DePonte that CT-scans offer more a more specific picture of the miner's lungs and measurements of the lesion can be more precise. Thus, there is no basis in Dr. Robinette's reports or testimony, nor is there evidence elsewhere in the record, to support a finding that the mass in the miner's lung is "healing."

To the contrary, Dr. DePonte, a dually-qualified physician, persuasively testified that the mass progressively worsened from the time of a 1997 x-ray study:

> If you look, it is very subtle, you have all the overlying rib shadows here. There is an opacity here that is about 3 centimeters . . .. Then there is another opacity with some smaller ones around that . . .. This measures just over 2. You sum that together and it gives you a B opacity of 5. It is two separate lesions. Two large ones and also smaller ones around that. *If you look on the subsequent film, you will find one of these is more large or was an oval opacity here and all these lung markings that were present up here have increased*, and this area, this conglomerate mass of the lung essentially pulls the smaller opacities together. Although you make the argument none of the other readers saw the opacities, you can see this can be very subtle.

CX. 3 at 27-28 (italics added). Her testimony was based on first-hand observations of the studies at the time of her deposition. Given Dr. DePonte's superior radiological qualifications and experience reviewing x-ray studies of persons suffering from pneumoconiosis, this tribunal finds that the lesion in the miner's upper, right lung has not improved; rather, it has worsened.

D. Background of high profusion of simple pneumoconiosis

Finally, Dr. Hippensteel states that complicated pneumoconiosis usually occurs on a background of a high profusion of small opacities. Dr. DePonte, who has superior radiological qualifications, observed that, on the miner's later testing, the "lung markings that were present (in the upper lung area) have increased, and . . . this conglomerate mass of the lung essentially pulls the smaller opacities together." Thus, as a lesion increases in size, smaller opacities are pulled together and may seem fewer in number. Moreover, it is noted that Dr. Robinette observed a background of Category 2/3 simple pneumoconiosis on the most recent study of record dated January 2, 2003. This constitutes a higher profusion of small opacities than the profusion noted by Dr. Hippensteel in his earlier study. Consequently, this tribunal finds that the background profusion in the miner's lungs has increased more than noted by Dr. Hippensteel in his earlier study. In sum, this tribunal finds that the background profusion in the miner's lungs has increased over time and, the most recent x-ray study of record, produced findings of a higher profusion of background opacities than interpretations of earlier studies.

Upon review of the newly submitted medical data of record, it is determined that the miner has demonstrated that he suffers from complicated pneumoconiosis and Employer has presented insufficient evidence to rebut the presumption under § 718.203(b) that the disease arose from the miner's exposure to coal dust. Thus, the miner has established an applicable element of entitlement previously adjudicated against him and, under § 725.309, the entire record must be reviewed *de novo* to determine whether he is entitled to benefits.

In this case, there is an important span of time from the evidence relied on by Judge Morgan to deny benefits in 1998 and the newly submitted evidence, dating from November 2000 to January 2003 in the miner's subsequent claim. In this interim period, Drs. Robinette and DePonte found progression of the miner's disease, both in terms of Dr. DePonte's observations that the lesions forming the size B opacity have enlarged and Dr. Robinette's interpretation of the January 2003 study revealing an increased profusion of simple pneumoconiosis (Category 2/3). The newly submitted evidence is entitled to greater weight than evidence presented to Judge Morgan as the new evidence presents a more accurate assessment of the miner's deteriorating condition. *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992) (application of the "later evidence" rule is a reasonable way to "discount old nonqualifying test results or physical examinations in favor of subsequent results that reveal a deterioration of the miner's condition"). As a result, for reasons previously set forth in this *Decision*, the newly submitted evidence establishes the presence of simple and complicated coal workers' pneumoconiosis. The presence of complicated pneumoconiosis entitles Claimant to invocation of the irrebuttable presumption of total disability due to the disease under § 718.304. Employer has not presented evidence sufficient to rebut the presumption at § 718.203 that the disease arose out of coal mine employment and Claimant is entitled to benefits.

Onset of benefits

The miner's second claim was filed on March 1, 2001. The Board affirmed Judge Morgan's denial of benefits on February 25, 2000. The first x-ray evidence demonstrating the presence of complicated coal workers' pneumoconiosis since the Board's decision is Dr.

DePonte's interpretation of the December 14, 2000 study. As a result, benefits should commence as of December 1, 2000. Accordingly,

ORDER

The miner's claim for benefits under the Act is granted and Employer shall pay to Claimant all benefits to which he is entitled commencing as of December 1, 2000.

Within 30 days of the date of issuance of this *Decision*, Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366. Counsel for the Director and for Employer shall file any objections with this Office and with Claimant's counsel within 20 days of receipt of the petition for fees and costs. It is requested that the petition for services and costs clearly provide (1) counsel's hourly rate with supporting argument or documentation, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

A

Edward T. Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is:

Benefits Review Board
U.S. Department of Labor
P.O. Box 37601
Washington, DC 20013-7601

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).